

RED CLIFF COMMUNITY HEALTH CENTER  
88455 PIKE ROAD  
BAYFIELD, WI 54814

(715)779-3707

FINANCIAL POLICY

We would like to thank you for choosing Red Cliff Community Health Center and allowing us to provide for your healthcare needs. The policies listed herein have been approved by Tribal Council with the goal of providing the finest care and service to our patients at the least cost.

We are committed to providing you with the best possible care. In order to accomplish this, we need your assistance in reading and understanding financial responsibility and our payment policy. By signing this document, you agree to the following:

RESPONSIBILITY FOR THE BILL

- I agree that I am financially responsible for all items/services provided to me at the Red Cliff Community Health Center.
- I agree that payment for service, including co-pays, is due at the time service is rendered. Payment will be accepted in cash, checks, Mastercard or Visa.
- Payments made in full for medical/dental, on the day of service, will be given a twenty percent 20% "same day discount".
- I agree a \$30 charge will be applied to checks returned non sufficient funds.
- I agree that my account may not exceed four hundred dollars (\$400) at any given time.

ACCEPTANCE OF THIRD PARTY COVERAGE  
Medicare-Medicaid-Insurance-Worker's Compensation

- The Red Cliff Community Health Center will accept "Assignment of Benefits" on verified insurance policies and submit a bill to the carrier on the client's behalf.
- The Health Center does not make any assurances or guarantee of any kind that the charges for services I receive will be covered by Medicare, Medicaid or any Third Party payor.
- Any balance after Third Party coverage is due upon receipt of billing statement.
- I agree that a deposit of no less than fifty (\$50) may be required if third party coverage cannot be verified or is insufficient to cover the services rendered.

REJECTED CLAIMS

- I agree to pay Red Cliff Community Health Center for all services that are provided but are not covered by Medicare, Medicaid or other Third Party payor.

- I agree that it is my responsibility, not Red Cliff Community Health Center's, to negotiate for payment of a claim that is disputed by the payor.

#### PAYMENT ARRANGEMENTS

- The Red Cliff Community Health Center will make reasonable efforts to assist clients in meeting their financial obligations.
- Payment plans will be entered into at the Health Center's discretion.
- Payment installments must equal at least twenty percent (20%) of the balance.

#### OUTSTANDING ACCOUNTS

- Red Cliff Community Health Center will apply a one percent (1%) monthly finance charge to all outstanding accounts.
- The Health Center reserves the right to request deposits and payment for outstanding balances. Deposits will be based on outstanding balance plus client's share of the new services to be performed.

#### BAD DEBTS/LEGAL ACTION

- I agree that if my account is not paid in full or satisfactory arrangements made within the allowable time frames, the Health Center reserves the right to refer the account to an outside collection agency.
- I agree if my account is sent for collection, I will be required to pay a deposit on the day of service prior to being seen for any future visits.

#### SPECIAL CIRCUMSTANCES

- In an emergency, services may be provided regardless of the client's account status. Services will be provided for that issue alone.

The Business Office Staff and Management welcome the opportunity to discuss any aspect of the financial policy. We appreciate your confidence and strive to provide quality healthcare.

**ATTENTION:** This is a legal document. Please read carefully. By signing, you agree that you understand and accept the terms on this form.

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Signature of Client If minor, parent or legal guardian

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Date